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# *SURGICAL GLOBAL FEE PACKAGES*

**Final Report**

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# 1.0 INTRODUCTION

## 1.1 Statement of the Problem

The Omnibus Budget Reconciliation Act of 1989 (PL-101-239) contains provisions that significantly change the way Medicare reimburses for physician services. The current reasonable charge payment mechanism of actual, customary, and prevailing charges will be replaced by a resource-based relative value scale (RBRVS) fee schedule beginning in 1992. The fee schedule amount for a given service in a given locality will be computed by taking the national relative value components for the service, adjusting them by the geographic practice cost indexes for the locality, summing the results, and multiplying by a national conversion factor.

Basing physician payment on national relative values makes it necessary to establish national definitions of services. For surgical procedures this becomes particularly important. Most major surgical procedures have traditionally been reimbursed through a global fee that covers the operation itself and some predefined amount of pre and postoperative care. In the past, Medicare carriers have had considerable discretion in determining the types of services to be included and the duration of the time period covered.

With a national fee schedule, global fee definitions for surgery should be consistent across the country for two reasons. First, the resource-based relative values for surgical procedures are calculated using a standard mix of pre and postoperative services. Thus, RBRVS-based payments will be based on the assumption that a fixed number of follow-up visits, etc. are being provided by the surgeon. Second, in the absence of a consistent set of global fee definitions, surgeons may begin to extra-bill for related services in order to offset any revenue losses due to the fee schedule. Based on input from physicians and carriers and after consideration of the Physician Payment Review Commission recommendations, HCFA has developed a proposed rule for standard global fee definitions. The final rule when implemented will apply to all major surgeries performed in all parts of the country.

The use of standard global fee definitions also raises a technical issue related to the implementation of the new fee schedule. HCFA is calculating a multiplier called the conversion factor which transforms relative values into payment amounts. The initial conversion factor is to be budget neutral relative to what Medicare expenditures would otherwise be without the fee schedule. This conversion factor will be calculated by dividing the estimated 1991 payments for physician services by the total number of relative value units (RVUs) expected to be provided in 1991. This conversion factor is a national number which applies to all services. With a uniform global fee definition, HCFA might want to factor in the RVUs for any additional visits that may be billed separately under the new standardized global fee definition and subtract the RVUs for visits that will no longer be permitted.

## 1.2 The Proposed Surgical Global Fee Policy

The Health Care Financing Administration (HCFA) has recently announced its proposed rules for the fee schedule for physician services including the proposed national standardization of global surgery policy (Federal Register, Vol. 56, No. 108, June 5, 1991, p. 25,830 - 25, 832). The following provisions are included in this proposed policy:

- **Preoperative period**: Medicare would pay separately for the initial evaluation or consultation by the surgeon. All normal preoperative visits, in or out of the hospital made by the primary surgeon after the initial visit, will be included in the global fee. A preoperative period of thirty days has been proposed.
- **Intra-operative services**: All usual and necessary intra-operative services required for performance of the surgery would be included in the global surgery fee. HCFA's Bureau of Program Operations (BPO) has worked with carrier medical directors to develop a list of usual and necessary intra-operative services for each surgery.
- **Postoperative period for major surgical procedures**: All postoperative visits up to 90 days after the date of surgery would be included in the global fee, although certain specific procedures may require a longer recovery period, e.g., orthopedic procedures, open heart surgery. HCFA is currently requesting suggestions for which procedures require a longer postoperative global fee period.

- Minor surgical procedures (starred procedures and "scopies"): Medicare would not pay for visits that occur when the surgery or endoscopy is performed unless other documented services are performed at the same time. All postoperative services related to a surgery or "scopy" that occur within 30 days after the procedure is performed would be included in the global fee.

## 1.3 Overview of Report

In our earlier work on surgical global fees, we examined the impact of implementation of a national global surgical fee policy. We found that technical adjustments might be necessary as part of the fee schedule transition process. Specifically, the RVU base used to calculate the conversion factor might be constructed so as to reflect expected, rather than actual, 1991 billings. For example, if surgeons will be prohibited from submitting postoperative visit bills, then the RVUs associated with those bills should logically be excluded from the base. Our results suggested that a substantial number of visits would be affected by these adjustments.

Our original analyses were not sufficiently detailed at the procedure code level to make the necessary technical adjustments. In addition, the earlier work was limited only to the top 100 surgical procedure codes and was based on 1988 claims data.

In this report, we have used the most recent available data (1989 BMAD Beneficiary File) to calculate adjustments for each surgical procedure code. While the tables presented here present aggregate adjustment factors for the high volume surgical procedures, the same information has been made available to HCFA on a diskette on a visit code specific basis for all surgeries. These adjustments are based on the proposed rules for a national standardization of global surgery policy as described in the June 5, 1991 Federal Register. The purpose of this report is to provide assistance to HCFA in developing policies for the final rule.

Chapter 2 describes the data source for this study. Chapter 3 provides our calculation of technical adjustments to the conversion factor.

## 2.0 DATA AND METHODS

The primary data base for this study is a physician claims abstract file. This claims abstract includes billing information on all surgical procedure codes. These data were abstracted from the 1989 BMAD beneficiary file, a five percent sample of Medicare eligibles and all of their claims.

All surgical claims were pulled off the 1989 beneficiary file. For each identified surgical procedure all bills submitted by the surgeon for a period extending from 30 days prior to surgery to 90 days following were abstracted from the beneficiary file. This includes pre and postoperative visits and consultations, as well as intraoperative procedures. In order to ensure that the global fee periods are equal for all observations, surgeries occurring during the first month of the year or during the last three months of the year were not included in our analysis of major surgical procedures. The assignment of bills to each surgical procedure involved three steps: (1) identifying the primary surgeon responsible for the surgery; (2) defining whether the surgery performed was a major or minor procedure; and (3) deciding where to assign the visit or consult when two or more surgical procedures have overlapping global fee periods.

First, both provider ID and specialty were used to identify the surgeon. This is important, as it allowed us to disentangle multi-specialty groups in those cases where the specialty code 70 is not used to identify group practice. We included all specialties in our analysis. In a number of cases, more than one surgeon may submit bills for the same surgical procedure on the same day. (These may be co-surgeons, or assistants who failed to use the appropriate type of service category.) When this occurred, we defined the surgeon for global fee purposes as the one with the highest allowed charge. Claims would then be abstracted for this surgeon only.

Second, each surgical procedure was categorized as either a major procedure (for which the 90-day follow-up applies) or a minor procedure (which have a shorter follow-up of 30 days) in the following way. HCFA's Bureau of Program Operations (BPO) provided us with a list categorizing top volume procedure codes as either major or minor. This list was

developed by carrier medical directors that reviewed surgical procedures which occurred at least 1500 or more times in the 1989 BMAD beneficiary file. About 70,000 surgeries, accounting for 7 percent ($31 million) of the total dollar volume, remained, i.e., not classified by BPO as either a major or minor surgery. These remaining codes were compared with the list of minor procedures developed by CHER. All codes on this list were considered minor surgical procedures and those surgeries still left remaining were classified as major surgery. CHER's list of minor surgical procedures include the following:

- all starred (*) procedures, and all codes indented under the starred procedures;
- application of casts and strapping (29000-29799);
- vascular injection procedures (36000-36680);
- dentoalveolar structures (41800-41899);
- bladder introduction and urodynamics (51600-51799); and
- removal of foreign body from ear (69200, 69210, 69220).

Finally, the creation of a file that includes information about all surgical procedure codes raised methodological concerns surrounding the assignment of visit and consult bills when two or more surgical procedures have overlapping pre or postoperative periods. For example, if a minor procedure is performed some time during the global fee period for a major procedure and a visit is billed on that day, where should that visit be assigned? If visits are duplicated and assigned to more than one surgical code, then estimates of technical adjustments to the conversion factor will be correct on a procedure code basis but wrong in total. Alternatively, if each visit is assigned to just one of the appropriate surgeries, than the visit adjustments to the conversion factor will be correct in total, but wrong on a procedure code-specific basis.

Since, according to information received from HCFA, the technical adjustments to the conversion factor will probably be performed on an aggregate basis, the latter method of visit allocation was chosen. Visits occuring during more than one surgery's global fee periods were assigned to the surgery with the highest allowed charge.

One additional source of data was used for this study. HCFA's BPO, with the assistance of carrier medical directors, developed a list of ancillary services and intraoperative procedures that are typically done as part of a specific surgical procedure and should not be billed for separately. Only primary surgical procedures that had $5 million or more in total volume and intraoperative services with $1 million or more in total volume in 1989 are included in the BPO list.

## 3.0 CALCULATION OF TECHNICAL ADJUSTMENTS TO THE CONVERSION FACTOR

The conversion factor is a multiplier which transforms relative values into payment amounts. OBRA 1989 provisions require that the conversion factor for the first year of the fee schedule be budget neutral. That is, the conversion factor must produce total payments under the fee schedule equal to what they would have been had the current payment rules continued.

The initial conversion factor will be computed by dividing the total estimated 1991 payments for physician services by the total number of RVUs expected to be provided in 1991. This conversion factor will then be updated by the 1992 annual update factor to establish the initial 1992 conversion factor.

With standardized global fee definitions, adjustments may need to be made to the total number of RVUs used for the denominator (or the RVU base). This might be a desirable technical adjustment, if policymakers expect that the mix and number of visits provided in 1991 will change as a result of the new definitions. Specifically, the RVUs for any additional visits that would be billed separately under the new global fee definition could be added to the RVU base and the RVUs for any visits that would no longer be permitted could be subtracted. We estimated the changes in visits under the proposed global fee definitions in order to make recommendations to HCFA on how adjustments could be made.

We also calculated the percentage of surgeries with bills for specific intra-operative procedures. These intra-operative services will no longer be allowed under the proposed global fee policy and HCFA may want to adjust the conversion factor by subtracting the total number of RVUs for these services from the RVU base, as well.

### 3.1 Preoperative Visit Adjustments

Under the proposed global fee definitions, only one visit will be allowed per major surgery (the initial consult or evaluation) in the preoperative period. We examined the 30 day period prior to surgery for all major surgical procedures separately and as a whole.

The expected number of preoperative visits that might be provided if the proposed standardized global fee definitions were implemented were calculated in the following way. First, it was assumed that all surgeons would begin to bill for an initial visit or consultation prior to surgery; this would produce an increase in the number of preoperative visits for those procedures where surgeons traditionally have not submitted bills. At the same time, some physicians have been billing for more than one operative visit, and it was assumed that all of these "excess" visits would be disallowed.

Table 3-1 presents the net number of visits* per procedure that would need to be either added to (adjustment factor > 0), or subtracted from (adjustment factor < 0), the RVU base. Presented in this table are the high volume Medicare procedures and those in the same family of procedures. The total at the bottom of the table is for all major procedures, not just the ones presented. The adjustment factor was calculated separately for each procedure. Algebraically, the adjustment factor was calculated as follows:

$$ADJ_i = \frac{(\Sigma PROC_i - \Sigma PREVIS_i)}{\Sigma PROC_i}$$

where

$ADJ_i$ = the adjustment factor for the i-th surgical procedure;

$PROC_i$ = the number of i-th surgical procedures; and

PREVIS = the number of preoperative visits associated with the i-th surgery.

Using the first procedure on Table 3-1 (modified radical mastectomy) as an example, the adjustment factor was simply derived as: .064=(1573-1473)/1573. Positive adjustment factors indicate that more preoperative visits would be billed (and paid) in toto for that surgical procedure, and negative factors mean fewer visits would be allowed. If desired, policymakers could then use the adjustment factor to add or subtract visits (or more

*The term "visits" includes both consultations and all types of visits, regardless of setting.

TABLE 3-1

ADJUSTMENT FACTOR FOR 30 DAY PREOPERATIVE PERIOD

| Major Procedure | | Total Procedures | Total Visits | Adjustment Factor |
|---|---|---|---|---|
| 19240 | Mastectomy, modified radical | 1,573 | 1,473 | 0.064 |
| 27125 | Partial hip replacement | 820 | 592 | 0.278 |
| 27130 | Total hip replacement | 1,945 | 1,478 | 0.240 |
| 27132 | Conversion to total hip replace. | 138 | 102 | 0.261 |
| 27134 | Revision of total hip replace. | 253 | 148 | 0.415 |
| 27235 | Treatment of femoral fracture | 309 | 151 | 0.511 |
| 27236 | Open treatment of femoral frac. | 1,929 | 1,252 | 0.351 |
| 27244 | Open treatment of femoral frac. | 3,074 | 1,646 | 0.465 |
| 27447 | Total knee replacement | 2,419 | 1,831 | 0.243 |
| 27590 | Thigh amputation | 754 | 847 | -0.123 |
| 27880 | Leg amputation | 653 | 764 | -0.170 |
| 29881 | Knee arthroscopy | 812 | 757 | 0.068 |
| 32480 | Lobectomy, total or segmental | 478 | 536 | -0.121 |
| 33206 | Permanent pacemaker insertion | 351 | 547 | -0.558 |
| 33207 | Perm. pacemaker, ventricular | 1,493 | 2,329 | -0.560 |
| 33208 | Perm. pacemaker, AV sequential | 673 | 1,301 | -0.933 |
| 33405 | Aortic valve replacement | 464 | 151 | 0.675 |
| 33430 | Mitral valve replacement | 230 | 86 | 0.626 |
| 33510 | CABG, single graft | 277 | 176 | 0.365 |
| 33511 | CABG, two grafts | 658 | 457 | 0.305 |
| 33512 | CABG, three grafts | 1,375 | 823 | 0.401 |
| 33513 | CABG, four grafts | 1,129 | 688 | 0.391 |
| 33514 | CABG, five grafts | 428 | 239 | 0.442 |
| 33516 | CABG, six or more grafts | 117 | 82 | 0.299 |
| 34201 | Embolectomy, leg incision | 566 | 260 | 0.541 |
| 35081 | Abdominal aorta aneurysm | 596 | 639 | -0.072 |
| 35082 | Ruptured abdominal aorta aneurysm | 169 | 95 | 0.438 |
| 35102 | Abdominal aorta aneurysm, iliac | 247 | 201 | 0.186 |
| 35301 | Thromboendarterectomy | 1,565 | 1,659 | -0.060 |
| 35556 | Femoral-popliteal bypass graft | 376 | 433 | -0.152 |
| 35566 | Femoral-anterior bypass graft | 207 | 246 | -0.188 |
| 35646 | Aortofemoral, w/o vein graft | 210 | 213 | -0.014 |
| 35656 | Femoral-popliteal w/o vein graft | 543 | 479 | 0.118 |
| 36830 | Arterioven. fistula; nonautogenous | 1,124 | 482 | 0.571 |
| 43830 | Gastrostomy, temporary | 985 | 1,003 | -0.018 |
| 44005 | Enterolysis | 1,043 | 784 | 0.248 |
| 44120 | Enterectomy | 844 | 667 | 0.210 |
| 44140 | Partial colectomy | 2,218 | 2,436 | -0.098 |
| 44143 | Partial colectomy, with colostomy | 529 | 534 | -0.009 |
| 44145 | Partial colectomy, w coloprocto. | 535 | 558 | -0.043 |
| 47600 | Cholecystectomy | 1,475 | 1,158 | 0.215 |
| 47605 | Cholecystectomy w cholangiography | 2,481 | 2,515 | -0.014 |
| 47610 | Cholecystectomy w duct exploration | 886 | 916 | -0.034 |
| 49000 | Exploratory laparotomy | 852 | 667 | 0.217 |
| 49505 | Inguinal hernia repair | 3,440 | 2,748 | 0.201 |
| 49560 | Ventral hernia repair | 1,041 | 704 | 0.324 |
| 50360 | Renal homotransplantation | 206 | 55 | 0.733 |
| 50590 | Lithotripsy | 671 | 577 | 0.140 |
| 52601 | TURP | 7,384 | 9,692 | -0.313 |
| 58150 | Total hysterectomy | 952 | 733 | 0.230 |
| 58265 | Vaginal hysterectomy | 475 | 315 | 0.337 |
| 63005 | Laminectomy, one or two segments | 215 | 289 | -0.344 |
| 63017 | Laminectomy, more than two segments | 204 | 292 | -0.431 |
| 63030 | Hemilaminectomy, unilateral | 602 | 943 | -0.566 |
| 63031 | Hemilaminectomy, bilateral | 81 | 123 | -0.519 |
| 63042 | Hemilaminectomy, reexploration | 182 | 273 | -0.500 |
| 64721 | Neuroplasty, carpal tunnel | 1,888 | 1,435 | 0.240 |
| 65855 | Trabeculoplasty by laser surgery | 3,487 | 2,344 | 0.328 |
| 66170 | Fistulization of sclera | 1,015 | 416 | 0.590 |
| 66761 | Iridotomy by photocoagulation | 1,786 | 1,111 | 0.378 |
| 66821 | Laser surgery | 14,090 | 8,155 | 0.421 |
| 66983 | Lens procedure, intracapsular | 758 | 496 | 0.346 |
| 66984 | Lens procedure, extracapsular | 31,513 | 20,486 | 0.350 |
| 66985 | Lens insertion aft. cat. removal | 1,014 | 481 | 0.526 |
| 67036 | Vitrectomy | 397 | 289 | 0.272 |
| 67107 | Retina repair, sclera buckling | 482 | 278 | 0.423 |
| 67210 | Destruction of retina lesion | 2,214 | 1,254 | 0.434 |
| 67228 | Destruction of extens. retinopathy | 4,123 | 1,759 | 0.573 |
| Total | All Major Procedures | 245,002 | 171,499 | 0.300 |

Source: BMAD Beneficiary File, 1989.

accurately visit RVUs) to the RVU base. Specifically, the actual number of visits would be calculated as follows:

$$[ADJ_i * RVU_j) * \Sigma PROC_i]$$

where

$RVU_j$ = the RVUs associated with the j-th type of visit code.

Using modified radical mastectomy again as an example, the net addition to the RVU base would be calculated as follows: $[0.064 * RVU_j] * 1573$. Since the procedure frequency of 1,573 was derived from the truncated BMAD sample, furthermore, policymakers would need to "inflate" this number to reflect the universe of Medicare modified radical mastectomies in 1991.

The adjustment factors shown in Table 3-1 are those for the top volume procedures. CHER has provided HCFA with a complete list of adjustment factors for all surgical procedure codes. Furthermore, Table 3-1 was constructed for all visits and consultation codes combined. Policymakers could make the adjustment factor specific for each CPT-4 code (hence, the j-th type of visit code). The details necessary for these adjustments have also been provided to HCFA.

## 3.2 Same Day Billing Adjustments

### 3.2.1 Same Day Visit Adjustments

Additional visits billed at the time of a minor surgical procedure or endoscopy will not be allowed under the proposed global fee policy. Visits at the time of the procedure would be paid only if the visit was documented to include additional services (unrelated to the surgical procedure itself). If the conversion factor were to be adjusted, it would be necessary to calculate the average number of visits that may no longer be billed. The total number of visits and consultations billed on the day of the minor surgery were summed and then divided by the total number of minor surgeries to arrive at a possible adjustment factor.

Table 3-2 presents the results for selected high volume minor procedures separately and all minor procedures in total. Visits include both consultations and all types of visits regardless of setting. The last column displays the adjustment factor for the RVU base. On average, this factor was estimated at slightly more than one-quarter of a visit per surgery, -.257. That is, .257 visit RVUs would be subtracted from the RVU base for each minor surgical procedure or endoscopy if such an adjustment were to be made. This adjustment factor overstates somewhat the number of visits that no longer would be paid under the proposed rules since some of these visits might be documented legitimate additional visits. In addition, this number varies greatly by procedure, the range is from -.040 to -.743. We would recommend making an adjustment to the RVU base on a procedure specific basis. CHER has provided HCFA with information on the number of visits billed for each minor surgical procedure both in total and by individual CPT-4 visit code.

## 3.3 Postoperative Visit Adjustments

### 3.3.1 Major Surgical Procedures

The proposed global surgery definition would include all visits 90 days after surgery in the surgical fee. If our technical adjustments are to be made to the conversion factor, then the RVUs for those visits currently being billed would need to be subtracted from the RVU base in the denominator of the conversion factor. We summed the visits billed 90 days after surgery for the major surgical procedures and for all major surgeries together. Table 3-3 presents the total visits for selected high volume procedures and all major procedures in total. The last column is our recommended adjustment factor, or the average number of visits billed in the 90 day postoperative period.

As seen in the last row of Table 3-3, there was an average of .59 postoperative visits per major surgery. Looking across procedures shows how this average varies, from .228 for aortic value replacements (CPT-4 code 33405) to 1.83 for kidney transplants (CPT-4 code 50360). The high number of postoperative visits for pacemaker insertions, reflects the fact

TABLE 3-2

MINOR SURGICAL PROCEDURE BILLINGS FOR VISITS ON THE SAME DAY

| Minor Procedure | | Total Procedures | Total Visits | Adjustment Factor |
|---|---|---|---|---|
| 11100 | Single lesion biopsy | 35,784 | 12,044 | -0.337 |
| 11640 | Malignant lesion, <=.5cm | 4,344 | 387 | -0.089 |
| 11641 | Malignant lesion, .6 to 1 cm | 7,868 | 690 | -0.088 |
| 11642 | Malignant lesion, 1.1 to 2 cm | 8,123 | 716 | -0.088 |
| 11750 | Nail excision | 8,922 | 1,531 | -0.172 |
| 17000 | Single facial lesion | 79,020 | 13,332 | -0.169 |
| 17001 | Facial lesion, 2nd and 3rd | 48,390 | 1,184 | -0.024 |
| 17100 | Benign lesion, other than face | 35,570 | 6,190 | -0.174 |
| 19120 | Breast cyst excision | 4,770 | 192 | -0.040 |
| 20550 | Tendon sheath injection | 26,843 | 18,318 | -0.682 |
| 20610 | Arthrocentesis | 62,108 | 46,159 | -0.743 |
| 31500 | Endotracheal intubation | 9,254 | 4,298 | -0.464 |
| 31622 | Bronchoscopy, diagnostic | 5,518 | 1,351 | -0.245 |
| 31625 | Bronchoscopy, with biopsy | 3,321 | 796 | -0.240 |
| 33210 | Insertion of temp. pacemaker | 3,403 | 1,434 | -0.421 |
| 36489 | Central venous catheter | 16,480 | 3,625 | -0.220 |
| 36620 | Arterial catheterization | 13,230 | 1,467 | -0.111 |
| 43235 | Upper GI endoscopy | 25,585 | 5,091 | -0.199 |
| 43239 | Upper GI endoscopy, biopsy | 16,541 | 2,764 | -0.167 |
| 43260 | ERCP | 1,872 | 291 | -0.155 |
| 45300 | Proctosigmoidoscopy | 16,598 | 8,661 | -0.522 |
| 45330 | Sigmoidoscopy | 40,308 | 11,683 | -0.290 |
| 45378 | Colonoscopy, fiberoptic | 22,449 | 2,527 | -0.113 |
| 45380 | Colonoscopy, for biopsy | 8,139 | 891 | -0.109 |
| 45385 | Colonoscopy, lesion removal | 11,935 | 810 | -0.068 |
| 52000 | Cystourethroscopy | 32,168 | 9,132 | -0.284 |
| 52235 | Cystoureth., medium tumors | 1,157 | 116 | -0.100 |
| 52240 | Cystoureth., large tumors | 1,099 | 120 | -0.109 |
| 92982 | PTCA, single vessel | 3,891 | 1,357 | -0.349 |
| Total | All Minor Procedures | 1,537,990 | 394,746 | -0.257 |

Source: BMAD Beneficiary File, 1989.

TABLE 3-3

ADJUSTMENT FACTOR FOR 90 DAY POSTOPERATIVE PERIOD

| Major Procedure | | Total Procedures | Total Visits | Adjustment Factor |
|---|---|---|---|---|
| 19240 | Mastectomy, modified radical | 1,573 | 998 | -0.634 |
| 27125 | Partial hip replacement | 820 | 482 | -0.588 |
| 27130 | Total hip replacement | 1,945 | 935 | -0.481 |
| 27132 | Conversion to total hip replace. | 138 | 80 | -0.580 |
| 27134 | Revision of total hip replace. | 253 | 138 | -0.545 |
| 27235 | Treatment of femoral fracture | 309 | 151 | -0.489 |
| 27236 | Open treatment of femoral frac. | 1,929 | 1,030 | -0.534 |
| 27244 | Open treatment of femoral frac. | 3,074 | 1,387 | -0.451 |
| 27447 | Total knee replacement | 2,419 | 1,377 | -0.569 |
| 27590 | Thigh amputation | 754 | 366 | -0.485 |
| 27880 | Leg amputation | 653 | 511 | -0.783 |
| 29881 | Knee arthroscopy | 812 | 524 | -0.645 |
| 32480 | Lobectomy, total or segmental | 478 | 473 | -0.990 |
| 33206 | Permanent pacemaker insertion | 351 | 381 | -1.085 |
| 33207 | Perm. pacemaker, ventricular | 1,493 | 2,047 | -1.371 |
| 33208 | Perm. pacemaker, AV sequential | 673 | 984 | -1.462 |
| 33405 | Aortic valve replacement | 464 | 106 | -0.228 |
| 33430 | Mitral valve replacement | 230 | 120 | -0.522 |
| 33510 | CABG, single graft | 277 | 176 | -0.635 |
| 33511 | CABG, two grafts | 658 | 396 | -0.602 |
| 33512 | CABG, three grafts | 1,375 | 682 | -0.496 |
| 33513 | CABG, four grafts | 1,129 | 629 | -0.557 |
| 33514 | CABG, five grafts | 428 | 266 | -0.622 |
| 33516 | CABG, six or more grafts | 117 | 53 | -0.453 |
| 34201 | Embolectomy, leg incision | 566 | 200 | -0.353 |
| 35081 | Abdominal aorta aneurysm | 596 | 391 | -0.656 |
| 35082 | Ruptured abdominal aorta aneurysm | 169 | 113 | -0.669 |
| 35102 | Abdominal aorta aneurysm, iliac | 247 | 94 | -0.381 |
| 35301 | Thromboendarterectomy | 1,565 | 655 | -0.419 |
| 35556 | Femoral-popliteal bypass graft | 376 | 238 | -0.633 |
| 35566 | Femoral-anterior bypass graft | 207 | 113 | -0.546 |
| 35646 | Aortofemoral, w/o vein graft | 210 | 67 | -0.319 |
| 35656 | Femoral-popliteal w/o vein graft | 543 | 272 | -0.501 |
| 36830 | Arterioven. fistula; nonautogenous | 1,124 | 281 | -0.250 |
| 43830 | Gastrostomy, temporary | 985 | 563 | -0.572 |
| 44005 | Enterolysis | 1,043 | 646 | -0.619 |
| 44120 | Enterectomy | 844 | 512 | -0.607 |
| 44140 | Partial colectomy | 2,218 | 1,831 | -0.826 |
| 44143 | Partial colectomy, with colostomy | 529 | 488 | -0.923 |
| 44145 | Partial colectomy, w coloprocto. | 535 | 477 | -0.892 |
| 47600 | Cholecystectomy | 1,475 | 754 | -0.511 |
| 47605 | Cholecystectomy w cholangiography | 2,481 | 975 | -0.393 |
| 47610 | Cholecystectomy w duct exploration | 886 | 905 | -1.021 |
| 49000 | Exploratory laparotomy | 852 | 601 | -0.705 |
| 49505 | Inguinal hernia repair | 3,440 | 1,218 | -0.354 |
| 49560 | Ventral hernia repair | 1,041 | 417 | -0.401 |
| 50360 | Renal homotransplantation | 206 | 378 | -1.835 |
| 50590 | Lithotripsy | 671 | 321 | -0.478 |
| 52601 | TURP | 7,384 | 4,788 | -0.648 |
| 58150 | Total hysterectomy | 952 | 435 | -0.457 |
| 58265 | Vaginal hysterectomy | 475 | 167 | -0.352 |
| 63005 | Laminectomy, one or two segments | 215 | 80 | -0.372 |
| 63017 | Laminectomy, more than two segments | 204 | 117 | -0.574 |
| 63030 | Hemilaminectomy, unilateral | 602 | 296 | -0.492 |
| 63031 | Hemilaminectomy, bilateral | 81 | 49 | -0.605 |
| 63042 | Hemilaminectomy, reexploration | 182 | 95 | -0.522 |
| 64721 | Neuroplasty, carpal tunnel | 1,888 | 750 | -0.397 |
| 65855 | Trabeculoplasty by laser surgery | 3,487 | 1,994 | -0.572 |
| 66170 | Fistulization of sclera | 1,015 | 494 | -0.487 |
| 66761 | Iridotomy by photocoagulation | 1,786 | 914 | -0.512 |
| 66821 | Laser surgery | 14,090 | 4,783 | -0.339 |
| 66983 | Lens procedure, intracapsular | 758 | 355 | -0.468 |
| 66984 | Lens procedure, extracapsular | 31,513 | 16,246 | -0.516 |
| 66985 | Lens insertion aft. cat. removal | 1,014 | 432 | -0.426 |
| 67036 | Vitrectomy | 397 | 179 | -0.451 |
| 67107 | Retina repair, sclera buckling | 482 | 127 | -0.263 |
| 67210 | Destruction of retina lesion | 2,214 | 879 | -0.397 |
| 67228 | Destruction of extens. retinopathy | 4,123 | 1,249 | -0.303 |
| Total | All Major Procedures | 245,002 | 144,571 | -0.590 |

Source: BMAD Beneficiary File, 1989.

that many carriers have traditionally not reimbursed this procedure on a global fee basis. We would recommend that, if adjustments are to be made to the RVU base, they should be done on a procedure specific basis. CHER has provided HCFA with adjustment factors for all major surgical procedures.

3.3.2 Minor Surgical Procedures

Under the proposed rules all services related to recovery from a minor procedure will be included in the global fee for a period of 30 days after surgery. Table 3-4 displays the number of postoperative visits billed for high volume minor surgical procedures. Once again, this number overestimates the amount of visits that no longer would be paid under the proposed rules since some of these visits may be unrelated to the recovery from the surgery. The last column is the average number of visits billed in the 30 day preoperative period, our recommended adjustment factor. This number is negative because if an adjustment were to be made, these visits would be subtracted from the conversion factors RVU base.

For all minor surgical procedures about one-fifth of a visit is billed during the postoperative period for the surgeries presented in the table. PTCA had the highest postoperative billing rate. On average, 1.4 visits are billed in the 30-day postoperative period for this procedure.

3.4 Billing for Intraoperative Procedures

The proposed Medicare fee schedule would bundle all usual and necessary intra-operative services required for performance of the surgery included into the global surgery fee. Currently there are inconsistencies across carriers surrounding which services are part of a surgical procedure. Without a uniform definition of intra-operative procedures there is a potential for unbundling of services under the new fee schedule. For this reason, HCFA's Bureau of Program Operations (BPO) with the assistance of Medicare carrier medical directors, has recently developed a list of usual and necessary intra-operative services for high dollar volume surgeries (those surgeries with over $5 million Medicare volume in 1989).

TABLE 3-4

MINOR SURGICAL PROCEDURE BILLINGS FOR VISITS 30 DAYS POSTOPERATIVE

| Minor Procedure | | Total Procedures | Total Visits | Adjustment Factor |
|---|---|---|---|---|
| 11100 | Single lesion biopsy | 35,784 | 5,465 | -0.153 |
| 11640 | Malignant lesion, <=.5cm | 4,344 | 402 | -0.093 |
| 11641 | Malignant lesion, .6 to 1 cm | 7,868 | 661 | -0.084 |
| 11642 | Malignant lesion, 1.1 to 2 cm | 8,123 | 872 | -0.107 |
| 11750 | Nail excision | 8,922 | 1,302 | -0.146 |
| 17000 | Single facial lesion | 79,020 | 3,759 | -0.048 |
| 17001 | Facial lesion, 2nd and 3rd | 48,390 | 184 | -0.004 |
| 17100 | Benign lesion, other than face | 35,570 | 2,256 | -0.063 |
| 19120 | Breast cyst excision | 4,770 | 442 | -0.093 |
| 20550 | Tendon sheath injection | 26,843 | 7,054 | -0.263 |
| 20610 | Arthrocentesis | 62,108 | 18,694 | -0.301 |
| 31500 | Endotracheal intubation | 9,254 | 3,613 | -0.390 |
| 31622 | Bronchoscopy, diagnostic | 5,518 | 5,118 | -0.928 |
| 31625 | Bronchoscopy, with biopsy | 3,321 | 3,458 | -1.041 |
| 33210 | Insertion of temp. pacemaker | 3,403 | 2,932 | -0.862 |
| 36489 | Central venous catheter | 16,480 | 7,959 | -0.483 |
| 36620 | Arterial catheterization | 13,230 | 2,783 | -0.210 |
| 43235 | Upper GI endoscopy | 25,585 | 11,274 | -0.441 |
| 43239 | Upper GI endoscopy, biopsy | 16,541 | 7,792 | -0.471 |
| 43260 | ERCP | 1,872 | 1,299 | -0.694 |
| 45300 | Proctosigmoidoscopy | 16,598 | 4,466 | -0.269 |
| 45330 | Sigmoidoscopy | 40,308 | 12,884 | -0.320 |
| 45378 | Colonoscopy, fiberoptic | 22,449 | 6,897 | -0.307 |
| 45380 | Colonoscopy, for biopsy | 8,139 | 3,424 | -0.421 |
| 45385 | Colonoscopy, lesion removal | 11,935 | 2,993 | -0.251 |
| 52000 | Cystourethroscopy | 32,168 | 5,037 | -0.157 |
| 52235 | Cystoureth., medium tumors | 1,157 | 185 | -0.160 |
| 52240 | Cystoureth., large tumors | 1,099 | 151 | -0.137 |
| 92982 | PTCA, single vessel | 3,891 | 5,361 | -1.378 |
| Total | All Minor Procedures | 1,537,990 | 304,410 | -0.198 |

Source: BMAD Beneficiary File, 1989.

The BPO list of intra-operative services was used to try and estimate the extent of intra-operative billings. Table 3-5 presents for each major surgical procedure the percentage of cases with bills for specific intra-operative procedures. Table 3-6 presents the same information for minor surgeries. Intra-operative procedures are printed beneath the primary surgical procedures. The intra-operative procedures in Tables 3-5 and 3-6 are only those on the BPO list with submitted bills in 1989.

For example, looking at the first page of Table 3-5, 0.4 percent of partial mastectomy (19160) surgeries had bills for breast biopsy (19100) and 3.6 percent had breast cyst excision (19120) bills on the same day. For the majority of major surgical procedures, billing for intra-operative procedures is minimal, and often non-existent. A few types of surgeries, such as intracranial aneurysm, knee arthroscopy, and enterectomy have frequent intra-operative billings. Thirty eight percent of intracranial aneurysm surgeries, for example, had bills submitted for microdissection (CPT-4 code 61712) on the same day.

Intra-operative billings for the minor surgical procedures are also fairly infrequent. Skin grafts (CPT-4 codes 14040, 14060), PTCA (CPT-4 code 92982), and cardiac catheterizations (CPT-4 codes 93501-93561) are the "minor" procedures with the most frequent intra-operative billings. PTCA and cardiac catheterizations might have high billing rates for intra-operative procedures because they traditionally have not been considered surgery.

TABLE 3-5

INTRA-OPERATIVE BILLINGS FOR MAJOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 19160 | Mastectomy, partial | |
| | 19100 | 0.4% |
| | 19120 | 3.6 |
| 19162 | Mastectomy, partial; with axillary lymphadenectomy | |
| | 19100 | 0.7 |
| | 19101 | 1.4 |
| | 19120 | 2.1 |
| | 38745 | 0.7 |
| 19240 | Mastectomy, modified radical | |
| | 19100 | 0.6 |
| | 19101 | 4.3 |
| | 19120 | 11.8 |
| | 19160 | 1.5 |
| | 19180 | 0.6 |
| | 38525 | 0.1 |
| | 38745 | 0.1 |
| 20680 | Removal of inplant; deep | |
| | 11042 | 0.6 |
| 22554 | Arthrodesis, anterior interbody technique; | |
| | 20902 | 0.7 |
| 23420 | Repair of complete shoulder (rotator) cuff avulsion, chronic | |
| | 23412 | 0.6 |
| 23472 | Arthroplasty with glenoid and proximal humeral replacement | |
| | 23130 | 1.6 |
| | 23412 | 1.6 |
| 25600 | Treatment of closed distal radial fracture or epiphyseal separation; without manipulation | |
| | 29125 | 1.7 |
| 25605 | Treatment of closed distal radial fracture or epiphyseal separation; with manipulation | |
| | 25600 | 0.3 |
| | 29075 | 4.2 |
| | 29125 | 1.3 |
| 25610 | Treatment of closed, complex, distal radial fracture or epiphyseal separation; without external skeletal fixation or percutaneous pinning | |
| | 29075 | 2.8 |
| | 29125 | 1.0 |

TABLE 3-5 (continued)

INTRA-OPERATIVE BILLINGS FOR MAJOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 27132 | Conversion of previous hip surgery to total hip replacement | |
| | 27125 | 0.7% |
| | 27130 | 0.7 |
| 27134 | Revision of total hip arthroplasty | |
| | 27090 | 0.8 |
| 27138 | Revision of total hip arthroplast; femoral component only | |
| | 20680 | 2.5 |
| 27236 | Open treatment of closed or open femoral fracture | |
| | 27235 | 0.1 |
| 27447 | Total knee replacement | |
| | 20902 | 0.6 |
| | 27425 | 4.5 |
| 27487 | Revision of total knee arthroplasty; all components | |
| | 27447 | 1.8 |
| | 27486 | 0.9 |
| 27506 | Open treatment of closed or open femoral shaft fracture | |
| | 20902 | 4.6 |
| | 27502 | 0.3 |
| 27590 | Amputation, thigh, through femur, any level | |
| | 27596 | 0.4 |
| 28285 | Hammertoe operation; one toe | |
| | 28153 | 0.8 |
| | 28160 | 1.4 |
| 28292 | Hallux valgus correction; Keller, McBride or Mayo type procedure | |
| | 28270 | 6.3 |
| | 28288 | 2.8 |
| | 28290 | 0.9 |
| 28296 | Hallux valgus correction; with metatarsal osteotomy | |
| | 28270 | 7.8 |
| | 28288 | 1.0 |
| | 28290 | 1.0 |
| | 28292 | 3.0 |
| | 28298 | 3.8 |

TABLE 3-5 (continued)

INTRA-OPERATIVE BILLINGS FOR MAJOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 29425 | Application of short leg cast; walking or ambulatory type | |
| | 29405 | 0.3% |
| 29874 | Arthroscopy, knee, surgical; for removal of loose body or foreign body | |
| | 20610 | 1.4 |
| | 29870 | 4.1 |
| | 29875 | 4.1 |
| 29875 | Arthroscopy, knee, surgical; synovectomy, limited | |
| | 20610 | 1.0 |
| | 29870 | 4.8 |
| 29876 | Arthroscopy, knee, surgical; synovectomy, major, two or more components | |
| | 20610 | 3.4 |
| | 29870 | 6.9 |
| | 29874 | 4.6 |
| 29877 | Arthroscopy, knee, surgical; debridement/shaving of articular cartilage | |
| | 20610 | 1.1 |
| | 29870 | 3.6 |
| | 29874 | 2.9 |
| | 29875 | 5.8 |
| 29879 | Arthroscopy, knee, surgical; abrasion arthroplasty or multiple drilling | |
| | 29870 | 6.6 |
| | 29874 | 6.6 |
| | 29875 | 13.2 |
| | 29877 | 9.2 |
| 29880 | Arthroscopy, knee, surgical; with meniscectomy (Medial and lateral) | |
| | 29870 | 0.6 |
| | 29874 | 1.8 |
| | 29875 | 5.3 |
| | 29877 | 22.5 |
| | 29881 | 1.2 |
| 29881 | Arthroscopy, knee, surgical; with meniscectomy (Medial or lateral) | |
| | 20610 | 0.2 |
| | 29870 | 2.0 |
| | 29874 | 1.5 |
| | 29875 | 2.8 |
| | 29877 | 15.0 |

TABLE 3-5 (continued)

INTRA-OPERATIVE BILLINGS FOR MAJOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 31541 | Laryngoscopy, direct, operative, with operating microscope | |
| | 31525 | 1.0% |
| 32100 | Thoracotomy, major; with exploration and biopsy | |
| | 32020 | 5.8 |
| 32480 | Lobectomy, total or segmental | |
| | 32100 | 2.5 |
| 32500 | Wedge resection of lung, single or multiple | |
| | 32020 | 3.1 |
| | 32100 | 3.1 |
| 33206 | Insertion of permanent pacemaker; artrial | |
| | 33200 | 0.6 |
| | 33207 | 0.6 |
| 33207 | Insertion of permanent pacemaker; ventricular | |
| | 33200 | 0.1 |
| | 33206 | 0.1 |
| 33208 | Insertion of permanent pacemaker; av sequential | |
| | 33207 | 0.6 |
| 33510 | Coronary artery bypass, autogenous graft, single graft | |
| | 32020 | 0.4 |
| | 33210 | 3.6 |
| | 33570 | 0.4 |
| 33511 | Coronary artery bypass, autogenous graft, two coronary grafts | |
| | 32020 | 0.3 |
| | 33210 | 3.3 |
| | 33510 | 0.2 |
| | 37720 | 0.3 |
| 33512 | Coronary artery bypass, autogenous graft, three coronary grafts | |
| | 32020 | 0.6 |
| | 33210 | 4.6 |
| | 33510 | 0.2 |
| | 33570 | 0.5 |
| | 37720 | 0.1 |
| | 37730 | 0.2 |

TABLE 3-5 (continued)

INTRA-OPERATIVE BILLINGS FOR MAJOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 33513 | Coronary artery bypass, autogenous graft, four coronary grafts | |
| | 32020 | 0.8% |
| | 33210 | 3.5 |
| | 33510 | 0.4 |
| | 33570 | 0.6 |
| | 37720 | 0.1 |
| | 37730 | 0.2 |
| 33514 | Coronary artery bypass, autogenous graft, five coronary grafts | |
| | 32020 | 0.2 |
| | 33210 | 4.4 |
| | 33570 | 1.2 |
| | 37720 | 0.2 |
| | 37730 | 0.2 |
| 33516 | Coronary artery bypass, autogenous graft, six or more coronary grafts | |
| | 33210 | 4.3 |
| | 33570 | 2.6 |
| 34201 | Embolectomy or thrombectomy, by leg incision | |
| | 36140 | 2.7 |
| 35081 | Direct repair of aneurysm or occlusive disease, abdominal aorta | |
| | 49000 | 0.3 |
| 35102 | Direct repair of aneurysm or excision, abdominal aorta involving iliac vessels | |
| | 44005 | 0.8 |
| | 49000 | 0.4 |
| 35141 | Direct repair of aneurysm or excision and graft insertion for aneurysm or occlusive disease, common femoral artery | |
| | 35371 | 1.7 |
| | 35372 | 0.6 |
| | 35381 | 1.7 |
| 35371 | Thromboendarterectomy, common femoral | |
| | 35456 | 6.9 |
| 35556 | Bypass graft, with vein; femoral-popliteal | |
| | 37720 | 0.3 |

TABLE 3-5 (continued)

INTRA-OPERATIVE BILLINGS FOR MAJOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 43630 | Hemigastrectomy or distal subtotal gastrectomy; without vagotomy | |
| | 38100 | 1.9% |
| | 43610 | 0.4 |
| | 43830 | 2.3 |
| | 43840 | 0.4 |
| | 44005 | 2.7 |
| | 49000 | 0.8 |
| | 49255 | 2.3 |
| 43635 | Hemigastrectomy or distal subtotal gastrectomy; with vagotomy | |
| | 38100 | 0.6 |
| | 43610 | 0.6 |
| | 43630 | 0.6 |
| | 43640 | 0.6 |
| | 43830 | 3.6 |
| | 43840 | 1.2 |
| | 43860 | 1.2 |
| | 44005 | 3.0 |
| | 49000 | 1.8 |
| | 49255 | 0.6 |
| 43640 | Vagotomy including pyloroplasty | |
| | 38100 | 1.1 |
| | 43501 | 7.4 |
| | 43610 | 5.7 |
| | 43830 | 4.5 |
| | 43832 | 1.1 |
| | 43840 | 13.1 |
| | 44300 | 1.7 |
| | 44950 | 0.6 |
| 43832 | Gastrostomy, permanent, with contruction of gastric tube | |
| | 43750 | 0.2 |
| | 43760 | 0.2 |
| | 43830 | 0.4 |
| | 44005 | 0.8 |
| | 44300 | 0.4 |
| 43840 | Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury | |
| | 44005 | 1.2 |
| | 44600 | 0.4 |
| | 49000 | 2.0 |
| | 49010 | 0.4 |
| | 49255 | 1.2 |

TABLE 3-5 (continued)

INTRA-OPERATIVE BILLINGS FOR MAJOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 44005 | Enterolysis for acute bowel obstruction | |
| | 38500 | 0.1% |
| | 44950 | 0.2 |
| | 49000 | 1.9 |
| | 49255 | 1.1 |
| 44120 | Enterectomy, resection of small intestine; with anastomosis | |
| | 38500 | 0.1 |
| | 44005 | 10.9 |
| | 44020 | 0.7 |
| | 44130 | 1.1 |
| | 44600 | 1.4 |
| | 44950 | 0.1 |
| | 49000 | 2.0 |
| | 49255 | 0.8 |
| 44130 | Enteroenterostomy, anastomosis of intestine | |
| | 44005 | 9.0 |
| | 44600 | 1.2 |
| | 49000 | 2.4 |
| | 49255 | 1.8 |
| 44140 | Colectomy, partial; with anastomosis | |
| | 44005 | 2.4 |
| | 44130 | 0.2 |
| | 44600 | 0.5 |
| | 44950 | 0.2 |
| | 49000 | 0.7 |
| | 49010 | 0.1 |
| | 49255 | 0.6 |
| 44141 | Colectomy, partial; with skin level cecostomy or colostomy | |
| | 38500 | 0.6 |
| | 44005 | 2.3 |
| | 44140 | 1.1 |
| | 44600 | 0.6 |
| | 49000 | 0.6 |
| | 49010 | 0.6 |
| 44143 | Colectomy, partial; with end colostomy and closure of distal segment | |
| | 44005 | 3.0 |
| | 44600 | 1.1 |
| | 44950 | 0.4 |
| | 49000 | 2.5 |
| | 49255 | 0.6 |

TABLE 3-5 (continued)

INTRA-OPERATIVE BILLINGS FOR MAJOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 44144 | Colectomy, partial; with resection, with colostomy of ileostomy and creation of mucofistula | |
| | 44005 | 3.3% |
| | 44141 | 0.7 |
| | 44320 | 0.7 |
| | 49000 | 2.6 |
| | 49010 | 0.7 |
| | 49255 | 1.3 |
| 44145 | Colectomy, partial; with coloproctostomy | |
| | 44005 | 2.1 |
| | 44140 | 2.2 |
| | 44600 | 0.2 |
| | 44950 | 0.4 |
| | 49000 | 0.6 |
| | 49255 | 0.6 |
| 44150 | Colectomy, total, abdominal, without proctectomy | |
| | 44005 | 3.6 |
| | 44144 | 0.6 |
| | 44600 | 1.2 |
| | 49000 | 1.2 |
| | 49255 | 1.2 |
| 44160 | Colectomy, with removal of terminal ileum and ileocolostomy | |
| | 44005 | 2.5 |
| | 44140 | 1.6 |
| | 44144 | 0.3 |
| | 44600 | 0.6 |
| | 44950 | 0.6 |
| | 49000 | 0.9 |
| | 49255 | 1.9 |
| 44320 | Colostomy or skin level cecostomy | |
| | 44005 | 1.3 |
| | 44300 | 0.3 |
| | 49000 | 3.9 |
| | 49255 | 1.3 |
| 44625 | Closure of enterostomy, with resection and anastomosis | |
| | 44005 | 5.1 |
| | 44620 | 0.6 |
| | 49000 | 1.7 |
| 45110 | Proctectomy; complete | |
| | 44005 | 1.0 |
| | 44140 | 2.0 |
| | 44141 | 1.0 |
| | 44600 | 0.5 |

TABLE 3-5 (continued)

INTRA-OPERATIVE BILLINGS FOR MAJOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 46260 | Hemorrhoidectomy, internal and external, complex or extensive; | |
| | 46221 | 0.3% |
| | 46600 | 0.7 |
| | 46934 | 0.7 |
| 47600 | Cholecystectomy | |
| | 38500 | 0.1 |
| | 44005 | 0.7 |
| | 44950 | 0.3 |
| | 47480 | 0.1 |
| | 49000 | 0.7 |
| | 49255 | 0.5 |
| 47605 | Cholecystectomy; with cholangiography | |
| | 38500 | 0.2 |
| | 44005 | 0.8 |
| | 44950 | 0.3 |
| | 47420 | 0.3 |
| | 47600 | 0.2 |
| | 49000 | 0.4 |
| | 49255 | 0.2 |
| 47610 | Cholecystectomy with exploration of common duct | |
| | 44005 | 0.7 |
| | 44950 | 0.1 |
| | 47420 | 0.7 |
| | 47600 | 0.3 |
| | 47605 | 0.3 |
| | 49000 | 0.9 |
| 47612 | Cholecystectomy with choledochoenterostomy | |
| | 44005 | 5.0 |
| 47620 | Cholecystectomy with transduodenal sphincterotomy or sphincteroplasty | |
| | 47605 | 2.0 |
| | 49000 | 2.0 |
| 49201 | Excision or destruction by any method or intra-abdominal or retroperitoneal tumors or cysts or endometriomas; extensive | |
| | 44005 | 5.6 |
| | 49000 | 3.8 |
| | 49255 | 7.5 |
| 49505 | Repair inguinal hernia | |
| | 38500 | 0.1 |

TABLE 3-5 (continued)

INTRA-OPERATIVE BILLINGS FOR MAJOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 49510 | Repair inguinal hernia, with orchiectomy | |
| | 49505 | 1.3% |
| | 54520 | 5.3 |
| 49515 | Repair inguinal hernia, with excision of hydrocele or spermatocele | |
| | 49505 | 6.7 |
| | 55040 | 1.3 |
| 49520 | Repair inguinal hernia, recurrent | |
| | 49505 | 6.0 |
| 49530 | Repair inguinal hernia, recurrent; incarcerated | |
| | 49000 | 0.3 |
| | 49505 | 2.4 |
| 49565 | Repair ventral hernia, recurrent | |
| | 44005 | 3.0 |
| | 49000 | 1.0 |
| | 49560 | 0.5 |
| 49581 | Repair umbilical hernia | |
| | 49000 | 0.2 |
| 50230 | Nephrectomy, radical, with regional lymphadenectomy | |
| | 49010 | 0.4 |
| | 50220 | 0.8 |
| 51595 | Cystectomy, with bilateral pelvic lymphadenectomy | |
| | 51595 | 2.1 |
| 51840 | Anterior vesicourethropexy, or urethropexy | |
| | 49000 | 0.4 |
| | 53661 | 0.8 |
| | 57240 | 10.9 |
| 52500 | Transurethral resection of bladder neck | |
| | 52000 | 6.0 |
| | 52640 | 0.3 |

TABLE 3-5 (continued)

INTRA-OPERATIVE BILLINGS FOR MAJOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 52601 | Transurethral resection of prostate | |
| | 51040 | 0.3% |
| | 51700 | 0.1 |
| | 52000 | 1.5 |
| | 52214 | 0.1 |
| | 52275 | 0.6 |
| | 52276 | 0.8 |
| | 52281 | 0.7 |
| | 52500 | 0.5 |
| | 53020 | 0.2 |
| | 53600 | 0.3 |
| | 53601 | 0.1 |
| | 53620 | 0.1 |
| | 53675 | 0.1 |
| 55821 | Prostatectomy, suprapubic, subtotal, one or two stages | |
| | 51040 | 0.6 |
| 55831 | Prostatectomy, retropubic, subtotal | |
| | 55250 | 0.9 |
| 55845 | Prostatectomy, with bilateral pelvic lymphadenectomy | |
| | 51010 | 0.3 |
| | 52000 | 2.2 |
| 57260 | Combined anteroposterior colporrhaphy | |
| | 57240 | 0.4 |
| 57265 | Combined anteroposterior colporrhaphy; with enterocele repair | |
| | 57250 | 3.4 |
| | 57260 | 0.9 |
| | 57268 | 0.9 |
| | 57282 | 9.4 |
| 58150 | Total hysterectomy | |
| | 49000 | 1.5 |
| | 49010 | 0.1 |
| | 57520 | 0.5 |
| | 58700 | 0.3 |
| | 58720 | 3.4 |
| | 58740 | 3.3 |
| | 58940 | 0.2 |
| | 58951 | 0.1 |

TABLE 3-5 (continued)

INTRA-OPERATIVE BILLINGS FOR MAJOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 58720 | Salpingo-oophorectomy, complete or partial, unilateral or bilateral | |
| | 44950 | 0.4% |
| | 49000 | 1.8 |
| | 49010 | 0.4 |
| | 49180 | 0.4 |
| 61154 | Burr hole(s) with evacuation and/or drainage of hematoma; extradural or subdural; unilateral | |
| | 61210 | 1.3 |
| 61312 | Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural | |
| | 61712 | 0.5 |
| 61510 | Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, rupratentorial, except meningioma | |
| | 61312 | 0.7 |
| | 61712 | 2.6 |
| 61512 | Craniectomy, trephination, bone flap craniotomy; for excision of meningioma, supratentorial | |
| | 61304 | 1.1 |
| | 61312 | 3.4 |
| | 61712 | 15.7 |
| 61700 | Surgery of intracranial aneurysm, intracranial approach | |
| | 61312 | 6.7 |
| | 61313 | 5.0 |
| | 61712 | 38.3 |
| 63005 | Laminectomy for decompression of spinal cord, one or two segments | |
| | 62279 | 0.5 |
| 63017 | Laminectomy for decompression of spinal cord, more than two segments | |
| | 61712 | 1.5 |
| | 62278 | 0.5 |
| | 63005 | 0.5 |
| | 63047 | 1.5 |
| | 63048 | 0.5 |
| 63030 | Laminotomy for excision of herniated intervertebral disk, unilateral | |
| | 61712 | 3.5 |
| | 62278 | 0.2 |

TABLE 3-5 (continued)

INTRA-OPERATIVE BILLINGS FOR MAJOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 63035 | Laminectomy for exploration/decompression of spinal cord and/or cauda equina, thoracic | |
| | 61712 | 2.2% |
| 63042 | Laminotomy for herniated intervertebral disk, extensive or re-exploration | |
| | 63030 | 2.2 |
| | 63035 | 3.8 |
| 63047 | Laminectomy, for decompression of spinal cord, cauda equina and/or nerve root(s), single segment,lumbar | |
| | 61712 | 4.9 |
| | 62278 | 0.6 |
| | 63035 | 2.8 |
| 63048 | Laminectomy, for decompression of spinal cord, cauda equina and/or nerve root(s), each additional segment, cervical, thoracic or lumbar | |
| | 61712 | 0.4 |
| 64721 | Neurolplasty and median nerve at carpal tunnel | |
| | 20550 | 0.2 |
| | 29075 | 0.5 |
| | 29125 | 1.0 |
| 65730 | Keratoplasty, penetrating | |
| | 67500 | 1.0 |
| 66170 | Fistulization of sclera for glaucoma; trabeculectomy | |
| | 66625 | 1.4 |
| | 67500 | 1.2 |
| 66625 | Iridectomy, with cyclectomy | |
| | 66761 | 1.1 |
| | 67500 | 2.7 |
| 66830 | Removal of secondary membranous cataract, with corneoscleral section, with or without iridectomy | |
| | 66821 | 0.2 |
| 66983 | Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure) | |
| | 66625 | 4.0 |
| | 67005 | 0.4 |
| | 67500 | 0.8 |

TABLE 3-5 (continued)

INTRA-OPERATIVE BILLINGS FOR MAJOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 66984 | Extracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure) | |
| | 66625 | 0.4% |
| | 67005 | 0.2 |
| | 67500 | 1.0 |
| 66985 | Insertion of intraocular lens subsequent to cataract removal | |
| | 66625 | 0.2 |
| | 67500 | 1.1 |
| 67036 | Vitrectomy, mechanical, repair of retinal detachment | |
| | 66030 | 1.5 |
| | 67010 | 0.3 |
| | 67015 | 2.0 |
| | 67025 | 7.8 |
| | 67031 | 2.0 |
| | 67500 | 0.3 |
| 67038 | Vitrectomy, with epiretinal membrane stripping | |
| | 67015 | 3.2 |
| | 67025 | 3.2 |
| | 67036 | 2.4 |
| 67105 | Repair of retinal detachment, photocoagulation | |
| | 67500 | 1.3 |
| 67107 | Repair of retinal detachment, scleral buckling | |
| | 67015 | 3.3 |
| | 67101 | 4.1 |
| | 67105 | 1.0 |
| | 67141 | 6.2 |
| | 67145 | 0.8 |
| | 67208 | 1.7 |
| | 67210 | 0.2 |
| | 67500 | 0.2 |
| 67108 | Repair of retinal detachment, with vitrectomy | |
| | 67015 | 1.6 |
| | 67031 | 2.4 |
| | 67101 | 4.0 |
| | 67105 | 4.0 |
| | 67107 | 2.4 |
| | 67141 | 7.2 |
| | 67145 | 2.4 |
| | 67208 | 0.8 |
| | 67210 | 2.4 |

TABLE 3-5 (continued)

INTRA-OPERATIVE BILLINGS FOR MAJOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 67145 | Prophylaxis of retinal detachment without drainage, photocoagulation | |
| | 67141 | 0.2% |
| | 67500 | 1.2 |
| 67210 | Destruction of localized lesion of retina, photocoagulation | |
| | 67141 | 0.1 |
| | 67500 | 2.0 |
| 67227 | Destruction of extensive or progressive retinopathy | |
| | 67145 | 0.5 |
| | 67210 | 0.5 |
| | 67500 | 0.9 |
| 67228 | Destruction of extensive or progressive retinopathy; photocoagulation | |
| | 67210 | 0.3 |
| | 67500 | 2.4 |
| 67904 | Repair of blepharoptosis; (tarso)levator resection, external approach | |
| | 15822 | 1.6 |
| | 15823 | 7.9 |
| 67917 | Repair of ectropion; blepharoplast, extensive | |
| | 67914 | 0.8 |
| | 67916 | 0.8 |
| | 67950 | 6.7 |
| 67924 | Repair of entropion; blepharoplasty, extensive | |
| | 67921 | 1.0 |
| | 67923 | 0.3 |
| | 67950 | 2.7 |

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TABLE 3-6

INTRA-OPERATIVE BILLINGS FOR MINOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 11042 | Debridement; skin, and subcutaneous tissue | |
| | 11041 | 0.2% |
| 11043 | Debridement; skin, subcutaneous tissue and muscle | |
| | 11040 | 0.2 |
| | 11041 | 0.5 |
| | 11042 | 3.6 |
| 11400 | Excision, benign lesion, except skin tag, trunk, arms or legs; 0.5 cm or less | |
| | 11100 | 1.1 |
| | 11101 | 0.1 |
| 11401 | Excision, benign lesion, except skin tag, trunk, arms or legs; 0.6 to 1.0 cm | |
| | 11100 | 2.0 |
| | 11101 | 0.1 |
| 11402 | Excision, benign lesion, except skin tag, trunk, arms or legs; 1.1 to 2.0 cm | |
| | 11100 | 1.3 |
| | 11101 | 0.1 |
| 11403 | Excision, benign lesion, except skin tag, trunk, arms or legs; 2.1 to 3.0 cm | |
| | 11100 | 1.1 |
| | 11101 | 0.1 |
| 11421 | Excision, benign lesion, except skin tag, scalp, neck, hands, feet, genitalia; 0.6 to 1.0 cm | |
| | 11100 | 1.3 |
| | 11101 | 0.1 |
| 11422 | Excision, benign lesion, except skin tag, scalp, neck, hands, feet, genitalia; 1.1 to 2.0 cm | |
| | 11100 | 1.3 |
| | 11101 | 0.1 |
| 11440 | Excision, benign lesion, face, ears, eyelids, nose lips, mucous membrane; 0.5 cm or less | |
| | 11100 | 2.1 |
| | 11101 | 0.2 |

TABLE 3-6 (continued)

INTRA-OPERATIVE BILLINGS FOR MINOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 11441 | Excision, benign lesion, face, ears, eyelids, nose lips, mucous membrane; 0.6 to 1.0 cm | |
| | 11100 | 2.0% |
| | 11101 | 0.1 |
| 11442 | Excision, benign lesion, face, ears, eyelids, nose lips, mucous membrane; 1.1 to 2.0 cm | |
| | 11100 | 1.8 |
| | 11101 | 0.1 |
| 11601 | Excision, malignant lesion, trunk, arms, or legs; 0.6 to 1.0 cm | |
| | 11100 | 3.8 |
| | 11101 | 0.7 |
| 11602 | Excision, malignant lesion, trunk, arms, or legs; 1.1 to 2.0 cm | |
| | 11100 | 3.7 |
| | 11101 | 0.5 |
| 11603 | Excision, malignant lesion, trunk, arms, or legs; 2.1 to 3.0 cm | |
| | 11100 | 1.9 |
| | 11101 | 0.3 |
| 11621 | Excision, malignant lesion, scalp, neck, hands, feet, genitalia; 0.6 to 1.0 cm | |
| | 11100 | 2.7 |
| | 11101 | 0.4 |
| 11622 | Excision, malignant lesion, scalp, neck, hands, feet, genitalia; 1.1 to 2.0 cm | |
| | 11100 | 2.4 |
| | 11101 | 0.3 |
| 11640 | Excision, malignant lesion, face, ears, eyelids, nose, lips; 0.5 cm or less | |
| | 11100 | 3.4 |
| | 11101 | 0.3 |
| 11641 | Excision, malignant lesion, face, ears, eyelids, nose, lips; 0.6 to 1.0 cm | |
| | 11100 | 2.6 |
| | 11101 | 0.2 |

TABLE 3-6 (continued)

INTRA-OPERATIVE BILLINGS FOR MINOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 11642 | Excision, malignant lesion, face, ears, eyelids, nose, lips; 1.1 to 2.0 cm | |
| | 11100 | 2.5% |
| | 11101 | 0.2 |
| 11643 | Excision, malignant lesion, face, ears, eyelids, nose, lips; 2.1 to 3.0 cm | |
| | 11100 | 2.5 |
| | 11101 | 0.1 |
| 11644 | Excision, malignant lesion, face, ears, eyelids, nose, lips; 3.1 to 4.0 cm | |
| | 11100 | 2.4 |
| | 11101 | 0.3 |
| 11750 | Excision of nail and nail matrix | |
| | 11730 | 0.9 |
| 11752 | Excision of nail and nail matrix, with amputation of tuft of distal phalanx | |
| | 11750 | 1.4 |
| 14040 | Adjacent tissue transfer or rearrangement; defect 10 sq cm or less | |
| | 11420 | 0.1 |
| | 11421 | 0.4 |
| | 11422 | 0.1 |
| | 11423 | 0.3 |
| | 11440 | 0.4 |
| | 11441 | 0.9 |
| | 11442 | 1.2 |
| | 11443 | 0.3 |
| | 11621 | 0.6 |
| | 11622 | 0.7 |
| | 11623 | 1.6 |
| | 11640 | 0.4 |
| | 11641 | 2.3 |
| | 11642 | 8.7 |
| | 11643 | 5.1 |
| 14060 | Adjacent tissue transfer or rearrangement; defect 10 sq cm or less | |
| | 11440 | 0.3 |
| | 11441 | 0.9 |
| | 11442 | 1.7 |
| | 11443 | 0.7 |
| | 11640 | 0.8 |
| | 11641 | 4.4 |
| | 11642 | 11.1 |
| | 11643 | 5.0 |
| | 15823 | |
| | 15822 | 0.5 |

TABLE 3-6 (continued)

INTRA-OPERATIVE BILLINGS FOR MINOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 17000 | Destruction of facial or pre-malignant lesions; one lesion | |
| | 11100 | 1.5% |
| 17002 | Destruction of facial or pre-malignant lesions; three lesions | |
| | 11101 | 0.1 |
| 17101 | Destruction of benign skin lesions; one lesion | |
| | 11100 | 0.2 |
| 19120 | Excision of cyst, breast tissue; one or more lesions | |
| | 19100 | 0.2 |
| 20550 | Injection, tendon sheath, ligament | |
| | 10160 | 0.1 |
| 31536 | Laryngoscopy, direct, operative, with biopsy; with operating microscope | |
| | 31535 | 0.3 |
| 31625 | Bronchoscopy; with biopsy | |
| | 31622 | 1.2 |
| 31628 | Bronchocopy; with transbroncial lung biopsy | |
| | 31625 | 0.4 |
| 31645 | Bronchoscopy; with therapeutic aspiration of tracheobronchial tree | |
| | 31622 | 0.1 |
| 43239 | Upper GI endoscopy for biopsy | |
| | 43202 | 0.1 |
| | 43235 | 0.1 |

TABLE 3-6 (continued)

INTRA-OPERATIVE BILLINGS FOR MINOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 43246 | Upper GI endoscopy for directed placement of percutaneous gastrostomy tube | |
| | 43200 | 0.1% |
| | 43235 | 3.6 |
| | 43239 | 0.5 |
| | 43241 | 0.1 |
| | 43750 | 6.9 |
| | 43760 | 0.6 |
| 43247 | Upper GI endoscopy for removal of foreign body | |
| | 43200 | 0.2 |
| | 43235 | 0.9 |
| | 43239 | 2.0 |
| 43255 | Upper GI endoscopy for control of hemorrhage | |
| | 43204 | 0.3 |
| | 43235 | 1.6 |
| | 43239 | 0.7 |
| 43260 | Endoscopic retrograde cholangiopancreatography (ERCP) | |
| | 43200 | 0.1 |
| | 43234 | 0.2 |
| | 43235 | 5.3 |
| | 43239 | 2.0 |
| 43262 | Endoscopic retrograde cholangiopancreatography (ERCP) for sphincterotomy/papillotomy | |
| | 43235 | 2.5 |
| | 43239 | 1.2 |
| | 43260 | 4.2 |
| 43264 | Endoscopic retrograde cholangiopancreatography (ERCP) for removal of stone(s) | |
| | 43235 | 1.8 |
| | 43260 | 1.8 |
| 43268 | Endoscopic retrograde cholangiopancreatography (ERCP) for insertion of tube of stent | |
| | 43235 | 1.1 |
| | 43239 | 0.5 |
| | 43260 | 1.6 |
| 43750 | Percutaneous plaement of gastrostomy tube | |
| | 43234 | 0.3 |
| | 43760 | 0.2 |
| 45300 | Proctosigmoidoscopy | |
| | 46600 | 1.4 |

TABLE 3-6 (continued)

INTRA-OPERATIVE BILLINGS FOR MINOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 45330 | Sigmoidoscopy | |
| | 45300 | 0.2% |
| | 46600 | 0.7 |
| 45331 | Sigmoidoscopy, for biopsy | |
| | 45300 | 0.2 |
| | 45305 | 0.1 |
| | 45330 | 0.3 |
| 45378 | Colonoscopy, fiberoptic | |
| | 45300 | 0.1 |
| | 45330 | 0.2 |
| 45380 | Colonoscopy, fiberoptic, for biopsy | |
| | 45300 | 0.1 |
| | 45305 | 0.1 |
| | 45330 | 0.1 |
| | 45331 | 0.1 |
| | 45378 | 0.1 |
| | 46600 | 0.2 |
| 45383 | Colonscopy, for ablation of tumor or mucosal lesion | |
| | 45330 | 0.5 |
| | 45331 | 0.2 |
| | 45336 | 0.2 |
| | 45378 | 0.3 |
| | 46934 | 0.2 |
| 45385 | Colonoscopy, for removal of polypoid lesion | |
| | 45300 | 0.1 |
| | 45330 | 0.1 |
| | 45333 | 0.1 |
| | 45378 | 0.2 |
| 51720 | Bladder instillation of anticarcinogenic agent | |
| | 51700 | 0.4 |
| | 53670 | 6.4 |
| | 53675 | 0.3 |
| 51726 | Complex cystometrogram | |
| | 51725 | 0.1 |
| | 53670 | 2.3 |
| 52005 | Cystourethroscopy, ureteral catheterization | |
| | 51700 | 0.4 |
| | 52000 | 0.3 |
| 52007 | Cystiyrethroscopy, brush biopsy | |
| | 52005 | 6.8 |

TABLE 3-6 (continued)

INTRA-OPERATIVE BILLINGS FOR MINOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 52235 | Cystourethroscopy, medium bladder tumors | |
| | 51700 | 0.3% |
| | 52214 | 0.2 |
| | 52224 | 0.2 |
| | 52234 | 0.7 |
| 52240 | Cystourethroscopy, large bladder tumors | |
| | 51700 | 0.1 |
| | 52214 | 0.3 |
| | 52224 | 0.1 |
| | 52234 | 0.3 |
| | 52235 | 0.2 |
| 52276 | Cystourethroscopy, direct vision internal urethrotomy | |
| | 51700 | 0.5 |
| | 53600 | 1.0 |
| | 53601 | 0.1 |
| 53620 | 0.127 | |
| 52281 | Cystourethroscopy, calibration and/or dilation of urethral stricture or stenosis | |
| | 51700 | 1.4 |
| | 52000 | 0.1 |
| | 53600 | 0.2 |
| | 53601 | 0.1 |
| | 53620 | 0.1 |
| | 53660 | 0.2 |
| | 53675 | 0.6 |
| 52310 | Cystourethroscopy, removal of foreign body | |
| | 51700 | 0.3 |
| | 52000 | 0.8 |
| | 52281 | 0.4 |
| 52332 | Cystourethroscopy, insertion of indwelling ureteral stent | |
| | 52000 | 0.4 |
| | 52005 | 10.0 |
| 52336 | Cystourethroscopy, removal or manipulation of calculus | |
| | 52000 | 0.3 |
| | 52335 | 1.2 |
| 52337 | Cystourethroscopy, with lithotripsy | |
| | 52000 | 0.8 |

TABLE 3-6 (continued)

INTRA-OPERATIVE BILLINGS FOR MINOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 57454 | Endoscopy, with biopsies or biopsy of the cervix | |
| | 57452 | 0.6% |
| 57520 | Biopsy of cervix, circumferential | |
| | 57454 | 1.1 |
| | 58120 | 6.0 |
| 58120 | Dilation and curettage | |
| | 57410 | 2.5 |
| | 57505 | 0.5 |
| 62278 | Injection of anesthetic substance; lumbar or caudal epiural, single | |
| | 62289 | 0.6 |
| 62284 | Injection procedure of myelography and /or computerized axial tomography | |
| | 62270 | 1.5 |
| 92982 | Percutaneous transluminal coronary angioplasty; single vessel | |
| | 33210 | 6.9 |
| | 36140 | 0.2 |
| | 36230 | 0.4 |
| | 36620 | 0.4 |
| | 93545 | 2.5 |
| | 93561 | 0.1 |
| | 93562 | 0.2 |
| 93501 | Right heart catheterization; only | |
| | 33210 | 2.7 |
| | 36010 | 0.8 |
| | 36489 | 4.2 |
| | 36491 | 0.2 |
| | 93503 | 1.1 |
| | 93561 | 1.6 |
| | 93562 | 1.2 |
| 93503 | Right heart catheterization; placement of flow directed catheter (e.g., Swan-Ganz) | |
| | 36010 | 0.7 |
| | 36489 | 6.6 |
| | 36491 | 0.6 |
| | 93501 | 0.1 |
| | 93561 | 1.3 |
| | 93562 | 1.0 |

TABLE 3-6 (continued)

INTRA-OPERATIVE BILLINGS FOR MINOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 93505 | Endomyocardial biopsy | |
| | 36010 | 0.3% |
| | 93501 | 2.2 |
| | 93561 | 3.4 |
| 93510 | Left heart catheterization | |
| | 33210 | 2.3 |
| | 36600 | 0.2 |
| | 36620 | 0.4 |
| | 93503 | 1.2 |
| | 93562 | 0.2 |
| 93526 | Combined right heart catheterization and retrograde left heart catheterization | |
| | 33210 | 5.3 |
| | 36010 | 0.4 |
| | 36620 | 0.4 |
| | 93510 | 0.8 |
| | 93561 | 1.1 |
| | 93562 | 0.8 |
| 93536 | Percutaneous insertion of intra-aortic balloon catheter | |
| | 36489 | 1.4 |
| | 36620 | 1.0 |
| 93543 | Injection procedure during cardiac catheterization; for selective left ventricular of left atrial angiography | |
| | 93561 | 0.4 |
| | 93562 | 0.4 |
| 93544 | Injection procedure during cardiac catheterization; for aortography | |
| | 93561 | 0.6 |
| 93545 | Injection procedure during cardiac catheterization; for selective coronary angiography | |
| | 93562 | 0.7 |
| 93546 | Combined left heart catheterization and left ventricular angiography | |
| | 36620 | 0.6 |
| | 93503 | 6.1 |
| | 93510 | 0.6 |
| | 93562 | 1.7 |

TABLE 3-6 (continued)

INTRA-OPERATIVE BILLINGS FOR MINOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 93547 | Combined left heart catheterization, selective coronary angiography and selective left ventricular angiography | |
| | 33210 | 0.9% |
| | 36140 | 0.1 |
| | 36230 | 0.1 |
| | 36620 | 0.2 |
| | 93503 | 0.6 |
| | 93510 | 0.2 |
| | 93545 | 0.1 |
| | 93561 | 0.1 |
| | 93562 | 0.2 |
| 93548 | Combined left heart catheterization, selective coronary angiography and selective left ventriculography | |
| | 33210 | 1.2 |
| | 36230 | 0.8 |
| | 36620 | 0.1 |
| | 36625 | 0.1 |
| | 93503 | 1.7 |
| | 93510 | 0.1 |
| | 93544 | 0.6 |
| | 93545 | 0.1 |
| | 93546 | 0.1 |
| | 93547 | 0.6 |
| | 93561 | 1.0 |
| | 93562 | 0.1 |
| 93549 | Combined right and left heart catheterization, selective coronary angiography, and selective left ventricular angiography | |
| | 33210 | 3.1 |
| | 36140 | 0.1 |
| | 36230 | 0.1 |
| | 36489 | 0.4 |
| | 36620 | 0.1 |
| | 36625 | 0.1 |
| | 93503 | 0.7 |
| | 93510 | 0.1 |
| | 93526 | 0.1 |
| | 93544 | 4.2 |
| | 93545 | 0.1 |
| | 93547 | 0.1 |
| | 93561 | 2.2 |
| | 93562 | 1.4 |

TABLE 3-6 (continued)

INTRA-OPERATIVE BILLINGS FOR MINOR SURGICAL PROCEDURES

| | | Percentage Billing For Intraoperative Procedures |
|---|---|---|
| 93551 | Selective opacification of aortocoronary bypass grafts | |
| | 93545 | 1.2% |
| | 93562 | 0.4 |
| 93552 | Combined left heart catheterization, selective coronary angiography, selective left ventricular cineangiography and visualization of bypass grafts | |
| | 33210 | 0.5 |
| | 36620 | 0.1 |
| | 93503 | 0.8 |
| | 93510 | 0.4 |
| | 93545 | 0.2 |
| | 93547 | 0.3 |
| | 93562 | 0.7 |
| 93553 | Combined left heart catheterization with aortic root aortography | |
| | 33210 | 3.6 |
| | 36489 | 0.5 |
| | 36491 | 0.5 |
| | 36620 | 0.5 |
| | 93503 | 0.5 |
| | 93510 | 0.5 |
| | 93561 | 1.0 |
| 93561 | Indicator dilution studies; including arterial and/or venous catheterization | |
| | 36140 | 0.5 |
| | 36489 | 0.5 |
| | 36620 | 1.5 |
| | 93503 | 2.1 |
| | 93544 | 0.2 |
| | 93561 | 1.1 |

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